Medical Plan

Introduction

The ***Benefits by Design*** medical plan is designed to help you pay medical costs that result from serious or prolonged disabilities, and from ordinary injuries or illnesses.

The medical plan is a self–insured plan. This means that the company, not an insurance company, funds all medical claims from a budget set aside for this purpose. The claims administrator (Aetna in the case of general medical services, and CIGNA Behavioral Care in the case of mental health/chemical dependency treatment services) acts as claims fiduciary, and in this capacity has full discretionary authority to interpret the terms of the plan and to review, deny, and otherwise make final claim decisions.

Summary of Your Medical Benefits

Benefits by Design offers three medical plan choices–Plans A, B and C. (Employees who live in the Washington, DC area may also participate in the Kaiser Mid-Atlantic HMO. Information about the Kaiser HMO is available from the Benefits Office.) All three medical plans cover the same services. Additionally, for employees who live in the network area, all three plans incorporate a Preferred Provider Organization (PPO) for general medical care and the CIGNA Behavioral Care Program for mental health and chemical dependency care. (Employees who live outside the network area are not covered by the PPO for general medical services. These employees receive reimbursements for services that are covered under the plan using the in-network schedule of benefits subject to reasonable and customary allowances. Amounts that are charged in excess of reasonable and customary allowances are the responsibility of the employee.) You may not waive medical coverage unless you certify on your enrollment form that you have coverage through another plan.

The primary differences among the three medical plans are:

- The percentage of salary you pay as an annual deductible
- The percentage of covered expenses you pay after the deductible is met or if the deductible is waived
- The maximum percentage of salary you pay in a year before the plan pays 100% of covered expenses
- The cost and availability of the mail order prescription drug plan
- The monthly cost of coverage.

With the ***Benefits by Design*** program you can change your medical plan election each plan year. However, you may not **increase** your level of medical coverage more than one step each plan year. (For example, you may not move from Plan C to Plan A.) If you have previously waived coverage, you may enter Plan C during annual enrollment, but you may not move directly into Plan A or Plan B.

Preferred Provider Organization for General Medical Services

BBWI is a member of the Southeast Idaho Employers Coalition (SIEC), a group of large employers from our area that has developed a managed health care program known as a Preferred Provider Organization (PPO). The current PPO, which is owned and operated by CCN-Premier, was introduced within all three of BBWI's medical plans effective January 1, 1998.

The PPO is a network of hospitals, physicians, and other medical providers that have agreed to offer their services to BBWI employees at discounted rates. The SIEC PPO network includes physicians and hospitals in Idaho and Utah. Specific information about Southeast Idaho network providers is included in the PPO Directory that is published and distributed on a periodic basis during the year. Information about network providers in other parts of Idaho and in Utah may be obtained by calling 208-542-2851 (Idaho Falls number) or by contacting the Benefits Office. Because the PPO network of providers is subject to change, the most current PPO provider information may be obtained only by calling CCN-Premier at 208-542-2851. ***It is your responsibility to ensure that the doctor you choose is a member of the PPO network. Please remember to ask if your provider is an SIEC network provider at the time of your visit before any services are performed.***

Because of the discounted fee arrangement, both you and the company realize lower health care costs when you obtain your medical services through contracted PPO providers. To encourage you to take advantage of the PPO where possible, the medical plan schedule of benefits is less generous when services are not obtained through a network provider.

In reviewing the schedule of medical benefits, please note that while the "out-of-network" schedule will generally be applied to all services that are not obtained through the PPO network, it is recognized that there will be some situations when you or your dependents may be required by circumstances to use a nonparticipating provider. Examples of these situations are:

- When needed medical services are not available within the SIEC network (including Southeast Idaho, Boise, Idaho, and Utah providers).

- When medical services are obtained by your covered dependent who resides outside of the network service area, as in the case of a child who attends college in another state. Also, when medical expenses are received by employees who reside outside the network service area.

- When medical services are obtained because of an urgent illness or sudden medical condition that occurs when you are outside the network service area, as might occur during a vacation.

- When medical services are obtained for the initial treatment of a critical emergency or life-threatening situation.

In these situations, reimbursement for services obtained through a nonparticipating provider will be made at the "in-network" schedule of benefits (subject to the normal plan rules regarding medical necessity, reasonable and customary limitations, etc.). These are the only situations when out-of-network services will be reimbursed at the in-network level of benefits. This is true even if you are referred out-of-network by an in-network provider.

General Medical Coverage Overview

The table that follows summarizes the medical plan benefit levels for in-network and out-of-network general medical services. Please note that this table is provided only as a brief overview of your benefits. Some covered services may be subject to additional limitations or application of reasonable and customary allowances as explained in the detailed information that follows. (For example, all out-of-network and out-of-area charges, as well as all charges for routine physicals and cancer screening exams, are subject to reasonable and customary limitations.)

	Plan A Network Use In/Out	**Plan B** Network Use In/Out	**Plan C** Network Use In/Out
General Medical Services			
Annual Deductible – active employees (% of salary)			
Per Person	.5%/.5%	.8%/.8%	1.6%/1.6%
Per Family of 2	1.0%/1.0%	1.6%/1.6%	3.2%/3.2%
Per Family of 3 or more	1.25%/1.25%	2.0%/2.0%	4.0%/4.0%
Annual Deductible – retirees			
Per Person	$200/$200	$300/$300	$600/$600
Per Family of 2	$400/$400	$600/$600	$1,200/$1,200
Per Family of 3 or more	$600/$600	$900/$900	$1,800/$1,800
Deductible Waived			
Routine Physical Office Visits	Yes/Yes	Yes/Yes	Yes/Yes
Cancer Screening Office Visits	Yes/Yes	Yes/Yes	Yes/Yes
Inpatient Hospital	Yes/No	Yes/No	No/No
Surgery	Yes/No	Yes/No	No/No
Accidental Injury—treatment for 90 days which begins within 48 hours of the accident	Yes/No	Yes/No	No/No
Hospice Care	Yes/No	Yes/No	No/No
% Plan Pays			
Routine Physical Office Visits (no deductible)	100%/100%	100%/100%	100%/100%
Cancer Screening Office Visits (no deductible)	100%/100%	100%/100%	100%/100%
Other Services (after deductible)	80%/60%	80%/60%	70%/50%
Max You Pay Before Plan Pays 100% – active employees (% of salary-does not include deductible)			
Per Person	3%/6%	5%/10%	10%/20%
Per Family	6%/12%	10%/20%	20%/40%
Max You Pay Before Plan Pays 100% – retirees (does not include deductible)			
Per Person	$1,000/$2,000	$1,500/$3,000	$3,000/$6,000
Per Family	$2,000/$4,000	$3,000/$6,000	$6,000/$12,000
Maximum Lifetime Benefit	$1,000,000	$1,000,000	$1,000,000
Mail Order Drug Copayment	$10	$15	N/A
Retail Drug Card Copayment	20%	20%	30%
Utilization Review	Required	Required	Required

The annual deductible and out-of-pocket limits are expressed as a percentage of annual base pay not in excess of $80,000 (determined annually in January).

Plan Deductibles for General Medical Services. The annual deductibles for an individual and family vary depending on your salary and the plan you choose. Most unreimbursed out-of-pocket medical expenses will apply to satisfy your deductible. Charges that do not apply to your deductible include:

- Your copayment for prescription drugs purchased through the mail order prescription drug program and/or the retail drug card program
- Your deductible and/or copayments for mental health and/or substance abuse treatment under the CIGNA Behavioral Health program
- Charges in excess of R&C allowances
- Charges in excess of the plan's maximum allowances for routine physical examinations
- Charges for services that are not covered
- Charges for services for which the deductible is waived
- The $300 excluded amount for not complying with the preadmission review procedures (see "Cost Management Features").

When the family deductible limit is met in a calendar year, all individual deductibles will be considered to have been met for the remainder of that calendar year.

Expenses applied to the individual or family deductible in the last three months of the calendar year (October, November, December) may also be applied to the deductible for the **next** calendar year. This helps you avoid paying deductible charges late in one year and having to start over again in the following year.

Amount the Plans Pay for General Medical Services. After you have reached the individual or family deductible amount for the plan you choose, the plan begins paying a percentage of the reasonable and customary (R&C) charges for medical services covered under the plan.

When the individual deductible is satisfied, the plan will pay a portion of that individual's covered medical expenses for the remainder of the calendar year. When the family deductible is satisfied, the plan will pay a portion of the covered medical expenses of all covered family members for the remainder of the calendar year. The percentage paid depends upon the plan you choose and whether you obtain your services through the PPO network. Except as specifically noted in this Employee Handbook, the percentage paid for in-network services is 80% for Plans A and B, and 70% for Plan C. Out-of-network services are reimbursed at only 60% for Plans A and B, and at only 50% for Plan C.

Please note that if you do not obtain your medical services from a PPO provider, you will be personally responsible for all amounts that exceed the plan's R&C limitations. This is generally not the case if you use the PPO network, since network providers are not allowed to bill you for excess R&C charges on most services. The only exceptions are for costs associated with physicals and cancer-screening exams. Reimbursement of these costs is subject to R&C limitations even though the services are received from a network provider.

Out-of-Pocket Maximum for General Medical Services. There is a limit (subject to R&C limitations) on how much you will be required to pay each year for covered medical expenses. Generally, after you have paid a certain amount for covered medical expenses for one person during the year, the medical plan will pay 100% (subject to R&C limitations) of the remaining covered medical expenses for that person for the rest of the year. Similarly, after you have paid a certain amount for covered medical expenses for your family, the plan will pay 100% (subject to R&C limitations) of the remaining covered medical expenses for all covered family members for the rest of the calendar year.

The maximum amount you pay each year is calculated as a percentage of your annual base pay not in excess of $80,000. The percentage used depends upon the plan you choose and whether you obtain your services through the PPO network. For all three medical plans, the out-of-pocket maximum is twice as much for out-of-network services as for in-network services.

The following rules are used in allocating costs to your in-network and out-of-network out-of-pocket maximums:

- In-network expenses reduce both in-network and out-of-network out-of-pocket maximums
- Out-of-network expenses reduce only the out-of-network out-of-pocket maximum
- The total of both the in-network and out-of-network out-of-pocket maximums cannot exceed the out-of-network maximum.

Charges that do **not** apply to either the in-network or the out-of-network out-of-pocket maximum include:

- Your copayment for prescription drugs purchased through the mail order or retail drug programs
- Your copayment for mental health and/or substance abuse treatment under the CIGNA Behavioral Health program
- The $300 excluded amount for not complying with the preadmission review procedures (see "Cost Management Features")
- Charges greater than the R&C amount

- Charges in excess of the plan's maximum allowances for routine physical examinations
- Charges for services that are not covered under the plan
- Amounts applied to the deductible.

Expenses applied to the individual or family out-of-pocket maximum in the last three months of the calendar year (October, November, December) may also be applied to the out-of-pocket maximum for the **next** calendar year.

Maximum Lifetime Benefit. The maximum lifetime benefit for all medical services (including mental health and chemical dependency services) is $1 million per covered person.

Covered General Medical Services

The plan pays the prescribed portion of R&C charges for the following covered general medical expenses incurred by you or your dependents while covered under the plan. To be covered under the plan, the services and supplies must be prescribed by a physician legally licensed to practice medicine and surgery, for the treatment of injuries and illnesses that are not work-related (e.g., not covered by Worker's Compensation). Also, except for elective routine physical examinations and cancer-screening exams, the medical services/supplies must be medically necessary as defined in the plan (see "Definitions"). To be eligible for reimbursement, claims for covered expenses must be filed within 12 months of the date of service.

Routine Physical Examinations.

You and your covered dependents will receive 100% reimbursement of reasonable and customary expenses (not subject to plan deductibles) for routine physical examinations, not to exceed specified age-related frequency schedules and benefit levels as described in the table below. Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Related laboratory and x-ray services will be reimbursed at 80% of reasonable and customary (70% for Plan C), up to a maximum of $200 per exam (not subject to plan deductibles). Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Amounts charged that exceed the maximum allowable benefit of $200 are the responsibility of the employee.

The frequency schedule and benefit levels applicable for routine physical examinations are as follows:

Age	Maximum Amount Payable
Newborn to age 2	$200 every calendar year* (multiple exams)
Age 2 to age 18	$100 every calendar year* (one exam)
Age 18 to age 35	$200 every three calendar* years (one exam)
Age 35 to age 50	$200 every two calendar* years (one exam)
Age 50 and over	$200 every calendar year* (one exam)
Plus related laboratory and x-ray services	$200 maximum each exam ($200 every calendar year* in the case of newborn to age 2)

* Calendar year refers to the 12-month period between January 1 and December 31.

A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified injury or disease.

For your dependent child:

- The physical exam must include at least the following services:
  - A review and written record of the patient's complete medical history
  - A check of all body systems
  - A review and discussion of the exam results with the patient or with the parent or guardian.
- A physical exam may also include the materials for and the administration of immunizations for infectious disease (including flu shots) and testing for tuberculosis. (However, a routine physical exam does not include a physician's office visit solely in conjunction with immunizations or testing for tuberculosis. Also, if a person has to make more than one visit to have a series of immunizations, the immunizations will be covered but a physician's office visit fee in connection with the immunizations will not be covered.)

A routine physical exam does not include:

- Services which are covered to any extent under any other group plan of your Employer
- Services which are for diagnosis or treatment of a suspected or identified injury or disease

- Exams given while the person is confined in a hospital or other facility for medical care
- Services which are not given by a physician or under his or her direct supervision
- Medicines, drugs, appliances, equipment, or supplies
- Psychiatric, psychological, personality or emotional testing or exams
- Exams in any way related to employment
- Premarital exams
- Vision, hearing or dental exams.

Newborn Well-Baby Care. In addition to the above, coverage is provided for the initial physical exam performed in the hospital by the pediatrician to determine the health of newborns. This service is not subject to plan deductibles. In-network/out-of-network copayments do apply.

Cancer Screening Tests. There are certain tests used in the early detection of cancer which are covered under the medical plan. The plan provides coverage for Prostate Specificity Antigen (PSA) blood tests for men and routine mammograms and standard PAP tests for women. (Please note that the benefit paid for more expensive PAP tests such as Papnet, AutoPap, and Thin Prep will be limited to the benefit allowed for the standard PAP smear test.) Coverage for these procedures includes a standard PAP smear each calendar year for women age 18 and over, one baseline mammogram for women between the ages of 35 and 39, and one routine mammogram or PSA test per calendar year for individuals aged 40 and over.

Charges for cancer screening office visits are paid at 100% of R&C rates, not subject to plan deductibles. Charges for covered tests are covered at 80% of reasonable and customary (70% for Plan C), and also are not subject to plan deductibles. Amounts charged in excess of reasonable and customary allowances are the responsibility of the employee.

Inpatient Hospital Expenses. The plans pay a percentage of hospital charges for room, board, services, and supplies incurred during a period of hospital confinement. The covered expense for room and board charges is based on the hospital's most common room rate.

To be eligible for benefits, the hospital confinement must be prescribed by a physician legally licensed to practice medicine and surgery, and be medically necessary as defined by the plan (see "Definitions" and "Cost Management Features" to ensure maximum benefits).

Inpatient hospital charges are not subject to plan deductibles if the services are provided by a PPO network hospital. Charges for out-of-network hospitalizations are subject to normal plan deductibles, and are reimbursed at the lower out-of-network level of benefits subject to R&C allowances.

Smoking Cessation. Coverage is provided for smoking cessation, limited to two 90-day treatment periods. This 180–day treatment period is the maximum lifetime benefit allowed under the medical plan.

R&C charges for (1) the initial office visit for smoking cessation treatment and (2) doctor recommended smoking cessation products are included in this coverage. These charges are not subject to plan deductibles if the services/products are obtained from PPO network providers. Charges for smoking cessation services and products that are not obtained through the PPO network are subject to normal plan deductibles. Regular in-network/out-of-network plan copayments apply to all charges.

X-ray and Laboratory Charges. R&C charges for x–ray and laboratory procedures that are prescribed by a physician (legally licensed to practice medicine and surgery) in connection with the treatment of a medical condition are covered, subject to plan deductibles and in-network/out-of-network copayments.

Surgery. The plans pay a percentage of R&C charges incurred for a surgical procedure and for necessary post-operative treatment related to the surgical procedure, including inpatient and/or outpatient facility charges. Charges for an assistant surgeon and anesthetist are covered when necessary. When two surgeries are performed under the same anesthetic, your benefit for the second and any subsequent procedures will be reduced. This means your total benefit for the surgeries will be less than the percentage of charges normally covered under the plan you choose.

For multiple surgeries or multiple surgeons in attendance during one operative session, or for services or supplies for which data is unavailable, the R&C charge will be determined (by Aetna) using the charges generally incurred for cases similar in nature and severity in the geographical area (region, state, etc.) where the services were actually performed.

Charges for in-network surgeries are not subject to plan deductibles. Charges for surgeries that are not obtained from PPO providers will be reimbursed using the out-of-network schedule of benefits and will be subject to plan deductibles.

Prescription Drugs. All coverage of prescription drugs is subject to the normal provisions of the medical plan as discussed in this Employee Handbook. For example, prescription drugs will only be covered if they are determined to be medically necessary. Additionally, no coverage is provided for (1) extemporaneously prepared combinations of raw chemicals or (2) combinations of federal legend drugs in a non-FDA approved dosage form.

Mail Order Rx Program. If you are covered under medical Plan A or B, you may choose to file for prescription benefits through the Eckerd Health Service (EHS) mail service program otherwise known as Express Pharmacy Services. The mail order program is not available under Plan C. Medications used on an ongoing basis which require a doctor's prescription and are currently covered under the medical plans may be filled using the mail order program.

The Express Pharmacy Services prescription drug program is designed for medications which are taken on an ongoing basis for the treatment of chronic or long-term conditions. Under Plan A, you can receive a 30- to 90-day supply of medication for a $10 copayment per prescription. Under Plan B, your copayment is $15. Your copayment is not reimbursable under the medical plan, and does **not** apply to your $1,000,000 lifetime maximum medical plan benefit, your medical plan deductible, or your out-of-pocket maximum. However, your copayment may be reimbursed from your Health Care Flexible Spending Account according to the provisions of that plan.

If you choose to use the mail order prescription drug program, your prescriptions are filled through Express Pharmacy Services and delivered to your home, postage paid. (Overnight delivery is available at an additional charge to you.) Included are reorder instructions for future prescriptions and/or refills. Please allow 3 weeks for delivery.

Retail Drug Card Program. The retail prescription program is intended for medications used in the treatment of acute conditions, such as a short-term illness, infection, or injury. This is particularly true for participants in Plans A and B, who are also able to use the mail order program. All medical plan participants, including those in Plan C, may purchase up to a 30-day supply of medications through the retail drug card program.

The retail drug card program is administered by Eckerd Health Services (EHS), using an extensive national network of pharmacies. Information about participating pharmacies may be obtained by contacting EHS toll-free at 1-888-562-3784.

With the retail drug card program, prescription drugs purchased at local pharmacies are not subject to medical plan deductibles. If you use one of the participating network pharmacies, you won't have to pay the full cost of the prescription at the time of purchase (and then file a claim for reimbursement). Instead, you pay only 20% (Plans A and B) or 30% (Plan C) of the negotiated cost of your medication at the time of purchase. You don't need to file any claims, since all of the paperwork is handled by EHS.

If you don't go to a participating network pharmacy, you will pay the full price of your medicine at the time of purchase and then file a claim for reimbursement. All claims for prescription drugs purchased on or after January 1, 1999, should be mailed to:

Eckerd Health Services
P.O. Box 2860
Pittsburgh, PA 15230-2860

Claims for prescription drugs purchased before January 1, 1999, should be mailed to Aetna, P.O. Box 578850, Oklahoma City, OK 73157-8850.

Prescription drugs purchased from non-network pharmacies will be reimbursed by EHS at 80% (Plans A and B) or 70% (Plan C). Please be aware that if you purchase your medications at a non-network pharmacy (or from a network pharmacy but don't use your retail prescription card),

your reimbursement will not be based on the price you paid. (This is true even if this plan pays as secondary coverage under the coordination of benefit provisions.) Instead, EHS will calculate your reimbursement using the discounted price you would have been charged by a network pharmacy. Because of this, your reimbursement will usually be less than 80% or 70% of the amount you actually paid for your medication. To illustrate, assume that a particular medication costs $50 at a non-network pharmacy, but only $40 at a network pharmacy. If you purchase the medicine from the non-network pharmacy, your reimbursement will be $32 (80% of $40) for Plan A or B, or $28 (70% of $40) for Plan C.

Your 20% or 30% share of the cost for prescription drugs purchased through the retail drug card program is not eligible for additional reimbursement under the medical plan, and does not apply to your $1,000,000 lifetime maximum medical plan benefit, medical plan deductible, or out-of-pocket maximum. Your copayment may be reimbursed, however, from your Health Care Flexible Spending Account according to the provisions of that plan.

Prescriptions During Hospital Confinement. Medications and drugs that are prescribed by a physician and dispensed by a hospital during a period of emergency, outpatient, or inpatient hospital confinement will be covered in accordance with the normal provisions of the medical plan. Claims for reimbursement of charges for these prescribed medications should be submitted to Aetna (P.O. Box 578850, Oklahoma City, OK 73157-8850) for processing and will be paid at 80% (Plan A or B) or 70% (Plan C) of the amount charged, subject to plan deductibles where applicable. Please note that your share of the cost of these medications will apply to both your $1,000,000 lifetime maximum medical benefit and to your out-of-pocket maximum.

Reimbursement for covered prescription medications during hospital confinements will be made by Aetna using in-network schedule of benefits.

Extended Care Facility Expenses. The plans pay a percentage of covered expenses incurred in an extended care facility (see "Definitions"), up to 60 days per period of confinement, as long as you or your covered dependent are **transferred directly to the facility from a hospital** where you were confined for treatment of a disease or injury for at least 3 consecutive days.

Care at the extended care facility must be for the same disease or injury for which you were hospitalized and must be supervised by a physician.

Covered charges under this provision include:

- Local ambulance charges between the hospital (in which care was initiated) and the extended care facility

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any charge for daily board and room in a private room over the private room limit.

- Use of special treatment rooms
- X-ray and lab work
- Physical, occupational or speech therapy
- Oxygen and other gas therapy
- Other medical services usually given by an extended care facility. This does not include private or special nursing, or physicians services.
- Medical supplies.

This section does not cover charges made for treatment of:

- Drug addiction
- Chronic brain syndrome
- Alcoholism
- Senility
- Mental retardation
- Any other mental disorder

Charges for extended care facilities and services are subject to normal plan deductibles and in-network/out-of-network copayments. Reimbursement of expenses for services received from out-of-network providers will also be subject to R&C limitations.

Home Health Care Expenses. The plans pay a percentage of covered expenses for up to 100 visits in the home each calendar year. To receive benefits, the covered person must be under the care of a physician and the services must be provided by a home health agency (see "Definitions") or by others under arrangements made by the agency. The services must be part of a home health care treatment plan established and periodically reviewed by the physician.

One home health care visit will consist of (a) a visit for covered services that are part of a home health care plan, or (b) up to four consecutive hours of service by a home health aide.

If necessary because of equipment needs, home health care services may also be provided on an outpatient basis at a hospital, extended care facility, or rehabilitation center, as long as the services are arranged by a home health agency and would be included as a covered inpatient hospital service under Medicare.

Covered home health care expenses include:

- Part-time or intermittent care by a R.N. or by a L.P.N. if a R.N. is not available
- Part-time or intermittent home health aide services for patient care
- Physical, occupational, and speech therapy
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
  - Medical supplies
  - Drugs and medicines prescribed by a physician
  - Lab services provided by or for a home health care agency.

This section does not cover charges made for:

- Services or supplies that are not a part of the home health care plan
- Services of a person who usually lives with you or who is a member of your or your spouse's family
- Services of a social worker
- Transportation.

Charges for home health care services are subject to normal plan deductibles and in-network/out-of-network copayments. Reimbursement of expenses for services received from out-of-network providers will also be subject to R&C limitations.

Hospice Care. The plans pay a percentage of covered charges for hospice care (see "Definitions") services for you or a covered dependent who is terminally ill. "Terminally ill" means the patient has 6 months or less to live.

Charges for hospice care obtained from PPO network providers are not subject to plan deductibles. Charges for out-of-network hospice care are subject to normal plan deductibles, and are reimbursed at the lower out-of-network level of benefits subject to R&C limitations.

Hospice care services must be provided while the terminally ill person is covered under this plan and after a physician certifies that the person is terminally ill. The terminal illness must result from a nonoccupational medical condition.

Hospice care benefits will be provided for up to 6 months from the date a physician certifies that the person is terminally ill. Benefits may be provided for a longer period of time if necessary as certified by the attending physician.

Covered hospice services must be provided or arranged by a hospice, and must be provided under a written hospice care program established and periodically reviewed by the hospice's medical director and team.

Inpatient hospice care in a hospital is also covered, as long as the hospital facility is operated by a hospice or provides inpatient care arranged by a hospice. Benefits will not be paid if the hospital hospice care includes any period of custodial care.

Inpatient hospice care can include one period of respite care per month while the terminally ill person is receiving hospice care benefits. "Respite care" is 5 consecutive days (or less) of inpatient care provided by a hospital for a terminally ill person who is under a hospice care plan. The respite care must be provided on an intermittent, nonroutine and occasional basis, and must provide a break from caring for the terminally ill person for those persons who usually provide the hospice care.

If the covered terminally ill patient dies while receiving hospice benefits, bereavement counseling for the surviving members of the family will be covered at the normal plan percentage (up to a maximum benefit of $250). To be eligible for this coverage, family members must obtain counseling within 12 months after the person's death.

Covered hospice care expenses include:

- Charges by a hospice facility, hospital, or extended care facility for room, board, supplies, and other services furnished to a person while a full-time inpatient for pain control and other acute/chronic symptom management. (This would not include any excess daily room and board charges resulting from a private room.)

- Services and supplies furnished to a person while not confined as a full-time inpatient.

- Charges made by a Hospice Care Agency for:

  – Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.

  – Medical social services under the direction of a physician. These include: (1) assessment of the person's social, emotional, and medical needs, and the home/family situation, (2) identification of the community resources which are available to the person, and (3) assisting the person to obtain the resources necessary to meet the person's assessed needs.

  – Psychological and dietary counseling.

  – Consultation or case management services by a physician.

  – Physical and occupational therapy.

– Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.

– Medical supplies.

– Drugs and medicines prescribed by a physician.

- Charges made by the providers below, but only if (1) the provider is not an employee of a Hospice Care Agency, and (2) such Agency retains responsibility for the care of the person.

  – A physician for consultant or case management services.

  – A physical or occupational therapist.

  – A Home Health Care Agency, for (1) physical and/or occupational therapy, (2) part-time or intermittent home health aide services for up to 8 hours in any one day, primarily to care for the person, (3) medical supplies, (4) drugs and medicines prescribed by a physician, and (5) psychological and dietary counseling.

This section does not provide coverage for:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to care of the person. These include sitter/companion services for either the person who is ill or other members of the family, transportation, housecleaning, and maintenance of the house.

Other Covered Medical Expenses. After you have satisfied the annual deductible for the plan you choose, the following medical services and supplies incurred during the calendar year will be covered under the plans if (1) they are not determined to be experimental in nature, (2) they are medically necessary, (3) they have not been considered under any other provisions of the plan, and (4) they are not excluded by the terms of the plan. Coverage of these services will be subject to normal in-network/out-of-network copayments.

- Charges made for diagnosis and treatment by a physician legally licensed to practice medicine and surgery, or who state law requires to be recognized as a physician for group insurance purposes. (Please note that chiropractors are not included.)
- Charges made by a nurse practitioner, surgery technician, or surgery assistant.
- To the extent not reimbursed by dental insurance, charges made by a qualified physician, dentist, or orthodontist for services and supplies involved in treating certain medical

conditions of the mouth, jaws, jaw joints, or supporting tissues (including bones, muscles, and nerves). Included are:

- Hospital services and supplies received for an inpatient hospital confinement that is medically necessary because of the person's condition.

- Surgery needed to (1) treat a fracture, dislocation or wound, (2) cut out cysts, tumors, or other diseased tissues, or (3) alter the jaw, jaw joints, or bite relationship by a cutting procedure when appliance therapy alone cannot result in functional improvement. Not included are cutting procedures for extractions, alveolectomy, dental alveoplasty, and/or repair of the teeth and gum.

- Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

- Treatment of accidental injuries to sound, natural teeth (does not include tooth breakage while chewing) or surrounding tissues sustained while covered under the plan. Included is dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition (1) natural teeth that were damaged, lost, or removed, or (2) other body tissues of the mouth that were fractured or cut due to injury. Any such teeth must have been either free from decay or in good repair, and firmly attached to the jaw bone, at the time of the injury. To be covered, the treatment must generally be done in the calendar year of the accident or the following calendar year.

  If crown/caps, dentures, bridgework, or in-mouth appliances are installed due to such injury, coverage will be provided only for the first crown needed to repair each damaged tooth, the first denture or fixed bridgework to replace lost teeth, and the in-mouth appliance used in the first course of orthodontic treatment after the injury.

- Orthodontic services in conjunction with orthognathic or craniofacial surgery to treat disease, injury, or severe congenital deformity. All expected services should be submitted to Aetna for a predetermination of benefits in order to verify that the anticipated services are a covered benefit.

Except as specifically provided above, no coverage is included under this section for:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services, whether or not the purpose of such services or supplies is to relieve pain

- Root canal therapy

- Routine tooth removal

- Removal, repair, restoration, or repositioning of teeth lost or damaged in the course of biting or chewing
- Repair, replacement, or restoration of fillings, crowns, dentures, or bridgework
- Periodontal treatment
- Dental cleaning, in-mouth scaling, planing, or scraping
- Myofunctional therapy, including muscle training therapy and training to correct or control harmful habits.

- Organ and tissue transplants. (See National Medical Excellence Program discussed later in this section.)

- Certain charges made by a registered nurse, or a currently licensed practical nurse, provided:
  - He or she is not a relative by blood or marriage
  - He or she does not reside in your home
  - The nursing care is necessary as evidenced by a written statement from the attending physician.

  Covered charges under this section include charges made by a R.N., L.P.N., or a nursing agency for skilled nursing care. For this provision, skilled nursing care includes the following services:

  - Visiting nursing care by a R.N. or L.P.N. Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
  - Private duty nursing by a R.N. or L.P.N. if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

  The following services are <u>not</u> <u>included</u> as skilled nursing care:

  - That part or all of any nursing care that does not require the education, training, and technical skills of a R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities.
  - Any private duty nursing care given while the person is an inpatient in a hospital or other health care facility.
  - Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting.

  - Care provided solely for skilled observation, except for one 4-hour period for no more than 10 consecutive days following the occurrence of (1) a change in patient medications, (2) the treatment by a physician of an emergency condition, or the onset of symptoms indicating the probable need for such treatment, (3) surgery, or (4) release from inpatient confinement.

  - Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by a R.N. or L.P.N.

- Charges for emergency transportation within the continental United States and Canada for the first trip to and from a hospital by professional ambulance, by regularly scheduled airline, or by air ambulance to and from the nearest hospital qualified to provide special treatment for the injury or illness.

- Sterilization and sterilization reversal.

- Anesthetics and oxygen.

- Chemotherapy and radiation treatment.

- Most prescription drugs and medicines, including drugs prescribed for treatment of mental disorders and alcoholism/drug abuse. Drugs and medicines may not be covered if prescribed in conjunction with non-covered services. (See Prescription Drugs as discussed earlier in this section.)

- Physician prescribed hormonal pellets.

- Hospital outpatient expenses for diagnosis or treatment of an illness.

- Rental fees (not including maintenance fees) up to the purchase price of durable medical equipment. This includes, but is not limited to, a hospital bed, a manual wheelchair, and equipment to administer oxygen. Your attending physician must provide documentation of medical necessity for the rental or purchase of the equipment (if purchase is more cost-effective). The cost of replacement and/or repair of equipment may be covered if it is cost-effective and medically necessary.

- Blood and blood plasma to the extent charges are not reduced by blood donations.

- Braces, crutches, and prostheses when medically necessary because of an injury or illness, including replacement charges when required because of a pathological change (but not repair, maintenance, or replacement due to wear), and colostomy supplies.

- An initial wig or hairpiece when prescribed by a physician to replace hair loss due to disease, injury, or treatment of disease (e.g. alopecia, areata, alapecia totalis, alopecia universalis burns, chemotherapy, fungus, lupus, or radiation therapy).

- Foot orthotics, if medically necessary and therapeutic, limited to either two left or two right, or to one pair (not multiple sets) per calendar year.

- Support stockings, if medically necessary and if they are the type that require a physician's prescription.

- Physiotherapy.

- Speech therapy by a physician or legally licensed speech pathologist to restore or rehabilitate fully developed speech loss due to an illness, injury, or congenital defect if surgery has corrected the defect prior to the therapy.

- Medically necessary mastectomies, and reconstructive surgery and prostheses following mastectomies. Covered members who receive benefits for a medically necessary mastectomy, and who elect breast reconstruction after the mastectomy, will receive coverage for:

  – Reconstruction of the breast on which the mastectomy was performed

  – Surgery on, and reconstruction of, the other breast to produce a symmetrical appearance

  – Prostheses

  – Treatment of physical complications of all stages of mastectomy, including lymphedemas.

  This coverage will be provided in accordance with plan provisions, subject to the same annual deductibles and copayment provisions that apply for the mastectomy.

- Hospital coverage for the mother and newborn child in connection with childbirth. Benefits for a hospital length of stay (in connection with childbirth) for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or to less than 96 hours following a delivery by cesarean section. Coverage will be provided for a shorter stay if the attending provider, after consultation with the mother, discharges the mother and/or newborn earlier than the minimum allowed hospital stay noted above. In this case, benefits will be payable for two post-delivery home visits by a health care provider.

  Payment of benefits under this section is subject to normal plan rules regarding hospital precertification.

Costs for Coverage

Contributions for medical coverage are made on a pre-tax basis. The cost depends on the plan you choose and the coverage classification you select (employee only, employee and family, employee and children, or employee and spouse). The company provides credits to help you pay the cost of this coverage.

If you can be covered under another group plan and choose to opt out of the LMITCO Medical Plan, you may receive a cash credit of $50 as an addition to your monthly pay. (This does not apply if you are covered in the ***Benefits by Design*** Medical Plan as a dependent of your spouse.) The $50 cash credit is treated as additional wages subject to normal income tax withholding.

Cost Management Features

The features described below are designed to help you be a better health care consumer and to help the company better manage health care costs.

Hospital Self-Audit Incentive Program. The Hospital Self-Audit Incentive Program rewards employees who identify excess charges on their hospital bills, and complete the process described below, within 90 days of their discharge or date of service.

If you find errors of $100 or more in your hospital bill, send the corrected bill, a copy of the incorrect bill, and a Hospital Audit Refund Application (obtained at your Benefits Office) to the Aetna claims office. You may be eligible for a cash incentive, ranging from $25 to a maximum of $1000, representing 25% of the total overcharge.

Hospital Preadmission Review. The medical plan includes a hospital preadmission review program to help determine the duration and medical necessity of your proposed hospital stay.

If your physician recommends **inpatient hospitalization** for any reason, you or a family member (or your physician) should contact the Aetna Care Review Unit at least 7 days **before** you are to be hospitalized. In case of an emergency admission, you or a family member (or your physician) must contact the Care Review Unit within 2 business days following admission, **even if you have been discharged by that time**. When calling the Care Review Unit, please be prepared to provide the doctor's name and telephone number, and expected date of hospitalization.

The number to use in contacting the Care Review Unit is:

1-800-624-2000.

After the initial call, the Care Review Unit will contact your physician to discuss the proposed hospitalization and obtain more information. You, the attending physician, and the hospital will be notified of the results of this review. If you do not agree with the results, you or your physician may request reconsideration of the decision by contacting the Care Review Unit. Although the medical plan will only pay for that portion of your hospital stay that is determined

by the Care Review Unit to be medically necessary, **you** always make the final decision about your treatment.

Please remember that **you have the responsibility to make sure your doctor has provided the required information to the Care Review Unit** to certify your hospitalization. If you do not follow the preadmission review procedure, $300 will be deducted from the benefits payable for these covered services. Additionally, if your inpatient hospitalization is not considered by Aetna to be medically necessary, the resulting charges will generally not be paid by this plan.

Continued Stay Review. A Care Review Unit staff member will periodically review your hospitalization and length of stay with your physician. If your physician recommends an extended length of stay beyond what was originally approved during the preadmission review, the Care Review Unit staff member will determine the medical necessity of an extended stay. If there is sufficient medical evidence to warrant additional time in the hospital, the reviewer will approve an extended length of stay and your coverage for the hospitalization will continue.

If your extended stay is **not** approved, a physician advisor associated with the Care Review Unit will notify you and your physician. If you do not agree with the decision, you or your physician may request reconsideration of the decision by contacting the Care Review Unit. While the final decision about your treatment is made by you, please be aware that an extended hospitalization that is not approved by the Care Review Unit will generally not be paid by BBWI's medical plan.

Medical Case Management. If you or a covered dependent sustains a severe nonoccupational injury or illness (see "Definitions"), an Aetna medical case management consultant will review your situation to help ensure that you or your dependent receives medically necessary and appropriate treatment for the condition. Severe nonoccupational injuries and illnesses include, but are not limited to, major head traumas, spinal cord injuries, severe burns, severe strokes, organ transplant situations, and neonatal high risk conditions.

To determine the benefits available under the medical plan in these situations, the medical case management staff will review the patient's condition for the following:

- Medical status
- Current and future treatment plans
- Long–term cost projections
- Appropriateness and effectiveness of care.

The medical case management consultant may recommend alternate methods of treating your or your dependent's condition to ensure that the most appropriate and cost-effective care is received. These alternate treatment methods may include transferring the patient from a hospital to an extended care facility, or arranging for in-home care. You, your family, and the attending physician will all be involved in any decisions regarding proper care.

In the administration of this section, the company may authorize the payment of claims which do not come within the specific benefit provisions of this plan if it determines that such payment is within the intent of the plan, or is in the best interest of the plan, but any such payments, although a valid charge against the plan, will not be considered to be a precedent in the disposition of other claims.

National Medical Excellence Program. In some situations, you or your dependents may be referred by Medical Case Management to Aetna's National Medical Excellence (NME) program.

The NME program coordinates all solid and bone marrow transplants and other specialized care that cannot be provided within a NME Patient's local geographic area. To be eligible for coverage under this section, a person must:

- Require any of the listed procedures/treatments for which the charges are a covered medical expense.
- Contact Aetna and be approved by Aetna as a NME patient, and
- Agree to have the procedure/treatment performed in the hospital designated by Aetna as the most appropriate medical facility.

If a person is approved as a NME patient and care is directed to a medical facility more than 100 miles from the person's home, the plan will pay a benefit for travel and lodging expenses, but only to the extent described below.

Travel Expenses. These are expenses incurred by a NME patient for transportation between his/her home and the medical facility to receive services in connection with a listed procedure or treatment.

Also included are expenses incurred by no more than one companion for transportation when traveling with a NME patient between the NME patient's home and the medical facility to receive such services.

For purposes of this section, a companion is a person whose presence as companion or caregiver is necessary to enable a NME patient to (1) receive services in connection with any listed procedure/treatment, or (2) to travel to and from a designated medical facility.

Lodging Expenses. These are expenses, up to the lodging expense maximum per night, incurred by a NME patient for lodging away from home while traveling between his/her home and the medical facility to receive services in connection with any listed procedure or treatment.

Also included are expenses, incurred by no more than one companion for lodging away from home:

- While traveling with a NME patient between the NME patient's home and the medical facility to receive services in connection with any listed procedure or treatment; or

- When the companion's presence is required to enable a NME patient to receive such services from the medical facility on an inpatient or outpatient basis.

For the purpose of determining travel and lodging expenses, a hospital or other temporary residence from which a NME patient travels in order to begin a period of treatment at the medical facility or to which he or she travels after dismissal from the medical facility at the end of a period of treatment will be considered to be the NME patient's home.

Travel and Lodging Benefits Maximum. For all travel and lodging expenses incurred in connection with any one NME procedure or treatment:

- The total benefit payable will not exceed the travel and lodging benefit maximum per episode of care, as determined by Aetna.

- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes a NME patient and ends on the earlier of (1) one year after the day the procedure is performed, or (2) the date the patient ceases to receive any services from the medical facility in connection with the procedure.

Benefits paid for travel and lodging expenses do not count against any person's lifetime maximum benefit.

Limitations. Travel and lodging expenses under this section do not include, and no benefits are payable for, any charges which are covered under any other part of this plan.

Predetermination for Surgical Benefits. If you want to know the surgical benefits under your plan before you agree to undergo a recommended surgical procedure, you should complete and file a PreSurgical Benefit Determination Form (available from the Benefits Office) with Aetna. Aetna will review your form and tell you and your physician how much of the surgery charges may be covered.

The predetermination of benefits is not intended to limit your choice of physicians or tell you or your physician what treatment and services should be performed. However, the predetermination does provide you and your physician with information on what is covered (subject to verification of medical necessity, etc.) and the benefit that may be payable. The predetermination does not represent a guarantee of benefits.

General Medical Expenses Not Covered

Expenses for services **not** covered under the plan include, but are not limited to, the following:

- Hospitalization, treatment, services, supplies, or drugs that are not medically necessary as determined by Aetna.

- Charges for mental health and substance abuse treatment. Coverage for these services is described below under "CIGNA Behavioral Health Program for Mental Health and Chemical Dependency Care."

- Charges greater than the R&C amount as determined by Aetna.

- Occupational accidents or illnesses for which benefits are payable under Worker's Compensation.

- Eye examinations for diagnosis or treatment of astigmatism, myopia, hyperopia, or eye refractions; or the fitting or cost of eyeglasses or contact lenses.

- Hospitalization, treatment, or services for radial keratotomy or any related surgery to correct vision.

- Fitting or cost of hearing aids.

- Plastic surgery, reconstructive surgery, cosmetic surgery, or other services or supplies (including hospital charges) which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. Exceptions are made to the extent these services are needed to:

  – Improve the function of a body part (that is not a tooth) that is malformed (1) as the result of a severe birth defect (including harelip or webbed fingers/toes), or (2) as the direct result of a disease or surgery performed to treat a disease or injury.

  – Repair an injury which occurs when the person is covered under the plan.

- Hospitalization, examinations, or medical/surgical services and supplies that are determined by Aetna, CIGNA, or Eckerd's (as applicable) to be experimental or investigational.

  A drug, device, procedure, or treatment will be determined to be experimental or investigational if:

  – There is insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.

  – If required by the FDA, approval has not been granted for marketing.

– A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes.

– The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion may not apply with respect to services or supplies (other than drugs) received in connection with a disease if Aetna, CIGNA, or Eckerd's (as applicable) determines that:

– The disease can be expected to cause death within one year, in the absence of effective treatment, and

– The care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, Aetna, CIGNA, or Eckerds (as applicable) will take into account the results of a review by a panel of independent medical professionals selected by Aetna (or CIGNA/Eckerd's as appropriate). This panel will include professionals who treat the type of disease involved.

Also (if Aetna (or CIGNA/Eckerd's as appropriate) determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease), this exclusion will not apply with respect to drugs that:

– Have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or

– Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute.

- Transplant and donor benefits for:

  – Any transplant expense when an approved alternate remedy is available

  – Any animal organ or mechanical equipment device or organs

  – Any financial consideration to the donor other than for a covered expense which is incurred during the transplant procedure.

- Hospitalization, examinations, or medical/surgical services and supplies which do not meet accepted standards of medical practice.

- Services and supplies furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents, or medicaid.)

- Any services, supplies, treatment, or hospitalization provided without the recommendation and approval of a licensed physician. Reimbursement of medical/surgical charges for services is limited to those services rendered by a physician licensed to practice medicine and surgery in the state in which the charge is incurred.

- Chiropractic services.

- Outpatient occupational therapy, except to restore functions lost as the result of an accident.

- TMJ (temporomandibular joint syndrome) treatment, except diagnosis and surgery.

- Vitamins, nutritional supplements, special diets, comfort or convenience services or supplies, nonprescription drugs, or prescriptions purchased under the company's mail order or retail Rx program.

- Birth control pills and devices, except where medically necessary (as determined by Aetna and/or Eckerd's) to treat a documented medical condition.

- Extemporaneously prepared combinations of raw chemicals, or combinations of federal legend drugs in a non-FDA approved dosage form.

- Prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces, or other mechanical aids; or other care, repair, removal, replacement, or treatment of teeth or surrounding tissues. The only exceptions are (a) treatment to sound natural teeth resulting from an accidental injury while covered under the plan (to the extent not covered under BBWI's dental insurance plan), (b) removal of a tumor or cyst in the mouth, or incision and drainage of an abscess or cyst, (c) any other oral surgery which doesn't involve any tooth structure, alveolar process, or gingival tissues, and (d) orthodontic services received as part of the staged treatment of serious medical conditions or congenital birth defects.

- Transportation or travel charges, except as specified in the "Other Covered Medical Expenses" section.

- Amniocentesis, ultrasound, or any other procedure used to determine the sex of a fetus, unless determined by Aetna to be medically necessary.

- Any expense related to treatment for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, as determined by the insurance company, and present significant symptomatic medical

problems), or any treatment of obesity (except surgery to treat morbid obesity), including dietary programs (except for laboratory charges in connection with monitoring the patient's medical condition).

- Any expense that is incurred because of an injury or illness resulting from war or any act of war, whether declared or undeclared.

- Treatment of a dependent child's newborn child, including complications.

- Hospitalization, examinations, or medical/surgical treatments and supplies furnished before you or your dependents were covered under this plan, or related to a period of hospital confinement before you were covered under this plan.

- Charges that would not have been incurred if coverage under this plan did not exist, or that you or your covered dependents are not obligated to pay (including expenses which are the responsibility of another coverage).

- Infertility treatment and any expense to promote fertility, including, but not limited to, fertility tests and any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, embryo transfer, embryo reduction, or any similar treatment or method.

- Any expense that is primarily for a person's education, training, or development of skills needed to cope with an injury or sickness.

- Custodial care, developmental care, or domiciliary care as determined by Aetna, etc.

- Any expense for sex transformations and any treatment related to sexual dysfunction that does not have a physiological or organic basis.

- Speech therapy, except to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.

- Charges for personal items such as television and telephone rentals while hospitalized.

- Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.

- Elective abortions, unless the life of the mother is in danger or severe complications arise (as determined by Aetna).

- Orthopedic shoes or other supportive devices for the feet unless attached as an integral part of a brace.

- Acupuncture or acupressure treatment except if services are rendered by a medical doctor and are determined to be medically necessary by Aetna.
- Services, treatment, education testing, or training related to learning disabilities or developmental delays.
- Care furnished mainly to provide a surrounding free from exposure that can worsen a person's disease or injury.
- Primal therapy, rolfing, psychodrama, megavitamin therapy, bioenergetic therapy, vision perception training, or carbon dioxide therapy.
- Services of a resident physician or intern rendered in that capacity.
- Marriage, family, child, career, social adjustment, pastoral, or financial counseling.

Filing Medical Claims

Aetna is the claims administrator for general medical expenses under all three medical plans.

Claims for general medical services should be mailed to Aetna at the following address:

Aetna
P.O. Box 578850
Oklahoma City, OK 73157-8850

Please note that most PPO providers will submit claims directly to Aetna on behalf of the patient. It is only if the PPO provider does not perform this service that employees will need to submit their claims to Aetna.

Claim forms for Aetna are available from the company reception desks in Idaho Falls offices, the site dispensaries, and the Benefits Office.

To avoid processing delays, please answer all questions when completing your claim form. As an employee, you are responsible for the accuracy of all data supplied on the claim form. Please be sure that all submitted bills include the following information:

- Name and address of provider of service
- Name, address, and company of employee
- Social Security Number of employee
- Name and birthdate of patient, and relationship of the patient to the employee

- Medical diagnosis
- Nature of services or supplies furnished
- Date and amount of charges incurred, and indication of any payment made
- BBWI's group number (701216).

Payments of Benefits. Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you advise Aetna otherwise by the time you file the claim.

Additionally, the plan may pay up to $1,000 of any benefit to any of your relatives whom it believes is fairly entitled to such payment. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Recovery of Overpayment. If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this plan may have with respect to such overpayment.

Assignments. Coverage under this plan may not be assigned. Medical benefits under the plan may be assigned, but only with authorization by Aetna.

Physical Examinations. Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This may be done (at no cost to you) at any reasonable time while certification or a claim for benefits is pending or under review.

Legal Action. You must file your claims within 12 months of the date of service or charges for the service will **not** be considered eligible for processing under BBWI's plan.

Generally, no legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, unless the condition was excluded from coverage on the date of the loss.

Additional Provisions. The following provisions apply to your coverage.

- You cannot receive multiple coverage under this plan because your spouse also works for BBWI. For example, if your spouse works for BBWI you are not allowed to carry coverage in your own name as a BBWI employee and also be carried as a dependent under your spouse's coverage.

- In the event of a misstatement of any fact affecting your coverage under this plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this plan. Additional provisions are described elsewhere in the Plan Document on file with your employer. If you have any questions about the terms of this plan or about the proper payment of benefits, you may obtain more information from your employer, or you may call Aetna at 1-877-801-0825.

Your employer hopes to continue this plan indefinitely but, as with all group plans, this plan may be changed or discontinued as to all or any class of employees.

CIGNA Behavioral Health Program for Mental Health and Chemical Dependency Care

The benefits available under BBWI's medical plan for mental health and chemical dependency care are administered through the CIGNA Behavioral Health program. The CIGNA program is included within all three medical plans. You do not enroll for this program separately from your general medical coverage.

The CIGNA program includes a nation-wide network of quality providers and is designed to ensure that you receive appropriate mental health and substance abuse care. By providing personal case management for each treatment plan, and by continually monitoring each patient's progress, this program ensures that the treatment received is of high quality and consistent with individual patient needs.

Under the CIGNA program, all treatment must be preauthorized by CIGNA in order for you to receive any reimbursement for mental health or substance abuse services. Please remember to call the CIGNA assessment and referral line at 1-800-455-8187 before you begin any mental health and/or substance abuse treatment. This includes any treatment for conditions such as Attention Deficit Disorder (ADD) and medication management, even if these services are obtained from a medical doctor instead of from a mental health care provider, as well as procedures such as psychological testing and biofeedback.

You may contact CIGNA by telephone 24 hours a day, seven days a week. Your call will be answered by an intake specialist who will ask you some questions in order to direct you to an appropriate provider. CIGNA has a national network of providers that includes hospitals, outpatient facilities, psychiatrists, psychologists, and master's level therapists. These providers must meet strict professional and licensure requirements in order to be included in the CIGNA network. Because CIGNA licenses its own providers, the CIGNA network may not include the same providers as the network developed for the CCN-Premier network for general medical services. Please contact CIGNA to make certain that your provider is a member of the CIGNA network.

When your mental health/substance abuse services are preauthorized by CIGNA and you obtain your services from a CIGNA provider, the cost of your services will be reimbursed at the "in-network" schedule of benefits. If you obtain preauthorization of your treatment from CIGNA and choose to seek treatment from a licensed provider who is <u>not</u> a CIGNA participating provider, you will be eligible only for a lower "out-of-network" level of benefits (please see the schedule of benefits that is provided later in this section). ***If you do not preauthorize your care with CIGNA, no benefits will be payable for the services you obtain. This is true even if your provider is a member of the CIGNA network.***

In the event you have an emergency, CIGNA will direct you to the nearest emergency room. If you are unable to call CIGNA in an emergency and you or your dependent are admitted to the

hospital for inpatient care, you or your family member must notify CIGNA by 5:00 p.m. on the next business day. Failure to do so could result in lower benefits or denial of coverage.

Summary of Mental Health Coverage. The table below summarizes the mental health and chemical dependency benefits for in-network and out-of-network services under the CIGNA program:

	Plan A Network Use In/Out	**Plan B** Network Use In/Out	**Plan C** Network Use In/Out
Mental Health Services			
Annual Deductible-Per Person	NA/$200	NA/$300	NA/$600
% Plan Pays After Deductible	80%/60%	80%/60%	70%/50%
Max You Pay Each Calendar Year Before Plan Pays 100%	$500/NA	$750/NA	$1500/NA
Inpatient Mental Health Care			
Max days per calendar year	60/20	60/20	60/20
Max days per lifetime	Unlimited/60	Unlimited/60	Unlimited/60
Outpatient Mental Health Care			
Max visits per calendar year	Unlimited/26	Unlimited/26	Unlimited/26
Max visits per lifetime	Unlimited	Unlimited	Unlimited
Chemical Dependency Treatment			
Max lifetime limit	$20,000	$20,000	$20,000

Please note the following specific provisions in reviewing this schedule:

- Employees who use CIGNA network providers for their mental health services do not have to satisfy a deductible before the plan begins to pay a portion of their cost. Employees who **do not** use network providers will need to satisfy a separate deductible for mental health services. Amounts applied to the deductible for mental health and chemical dependency services will not also be applied to the deductible for general medical services.

- Preauthorized mental health services obtained through the CIGNA network are reimbursed by the plan at 80% for Plans A and B, and 70% for Plan C. Preauthorized mental health services that are not obtained from participating providers are reimbursed at a lower rate (60% for Plans A and B, and 50% for Plan C), subject to reasonable and customary limitations as determined by CIGNA.

- Employees who obtain their preauthorized mental health care services from a contracted provider may receive full reimbursement from the plan after meeting a separate out-of-pocket maximum. Amounts applied to the out-of-pocket maximum for mental health and chemical dependency services will not also be applied to the out-of-pocket maximum for general medical services. Employees who do not use participating providers will not be eligible for full reimbursement from the plan. They must pay a portion of all charges incurred for services received from nonparticipating providers.

- The lifetime benefit available for chemical dependency treatment is $20,000. This $20,000 limit is included within the $1,000,000 maximum lifetime benefit allowed under the medical plan.

- All benefits paid for mental health services and chemical dependency treatment (including facility charges and supplies) are applied against the $1,000,000 maximum lifetime benefit allowed under the medical plan.

Mental and Nervous Conditions. The plans pay a percentage of preauthorized covered charges for diagnosis and treatment of mental/nervous disorders provided by a psychiatrist, psychologist, or licensed clinical social worker when the treatment is required for medical reasons. The plan also covers treatment by a licensed master's level counselor who is licensed for independent practice in the state in which he/she practices.

All services for mental and nervous conditions must be preauthorized by CIGNA to be eligible for reimbursement. Eligible services are reimbursed at a higher rate if obtained from a CIGNA network provider.

Alcoholism and Chemical Dependency Program. Inpatient and outpatient charges for alcohol or chemical dependency treatment in a hospital or licensed treatment facility are covered (to a maximum lifetime benefit of $20,000 per person) if:

- The charges are part of an active treatment program and

- CIGNA has pre-approved the program.

All services for alcoholism and chemical dependency treatment must be preauthorized by CIGNA to be eligible for reimbursement. Eligible services are reimbursed at a higher rate if obtained from a CIGNA network provider.

Case Management for Psychiatric Care or Chemical Dependency

Inpatient. To receive benefits under the CIGNA program, you must contact CIGNA before you or your covered dependent is confined overnight in the psychiatric unit of an acute care hospital or psychiatric hospital. Services are covered for treatment of mental illness or functional nervous disorder when the treatment is given for medical reasons and is authorized by CIGNA. Coverage for authorized inpatient mental health care obtained from a network facility is limited to 60 days

per calendar year. Coverage for authorized in-patient mental health care obtained from an out-of-network facility is limited to 20 days per calendar year. Inpatient services for mental health and chemical dependency care are reimbursed at a higher rate if obtained from a CIGNA network provider.

You must also use the CIGNA program for inpatient treatment of alcohol or chemical dependency. As indicated above, the maximum lifetime benefit payable for chemical dependency treatment is $20,000.

If you or a covered dependent need to be admitted to the psychiatric unit of an acute care hospital or psychiatric hospital, you, your physician, or your family member must call CIGNA before admission at:

1-800-455-8187.

In case of an emergency admission, you, your family member, or your physician must notify CIGNA by 5:00 p.m. of the first business day following admission. CIGNA will need the name and telephone number of the patient's provider, and the date of admission to the hospital.

A CIGNA representative will obtain necessary information and begin a case management process, working directly with the attending psychiatrist to help determine the length and medical necessity of the proposed hospital stay, and to establish follow-up review dates with the attending psychiatrist. The patient, hospital, and attending psychiatrist are notified of the results of the case management review. If you do not agree with the results, there are levels of additional review that you or the attending psychiatrist may request.

If you do not use the CIGNA program for psychiatric inpatient care, the services you obtain will not be eligible for reimbursement.

Outpatient. Outpatient treatment for mental/nervous and/or chemical dependency conditions is also subject to prior authorization by CIGNA. Coverage for authorized outpatient care obtained out-of-network will be limited to 26 sessions per year.

Inpatient and Outpatient services for mental health and chemical dependency care are reimbursed at a higher rate if obtained from a CIGNA network provider.

Mental Health Services Not Covered

The following mental health services are not eligible for reimbursement under BBWI's medical plan:

- Psychoanalysis or psychotherapy when these treatments are for training, marriage counseling, amplification or perfection of vocational skills, personality improvement, and similar conditions which cannot be specifically defined as a mental illness or functional nervous disorder.

- Any expense related to treatment for appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria, as determined by the CIGNA, and present significant symptomatic medical problems), or any treatment of obesity (except surgery to treat morbid obesity), including dietary programs (except for laboratory charges in connection with monitoring the patient's medical condition).

- Any expense for sex transformations and any treatment related to sexual dysfunction.

- Any testing that is psychoeducational in nature.

- Hospitalization, treatment, services, supplies, or drugs that are not medically necessary as determined by CIGNA.

- Charges greater than the R&C amount as determined by CIGNA.

- Occupational accidents or illnesses, to the extent covered by Worker's Compensation.

- Hospitalization, examinations, or medical services and supplies used for experimental procedures.

- Hospitalization, examinations, or medical services and supplies which do not meet accepted standards of medical practice.

- Treatment, supplies, or services in a hospital or other facility owned or operated by any government or agency, or which are paid for through a government program (except a program for civilian employees of a government).

- Any services, supplies, treatment, or hospitalization provided without the recommendation and approval of a licensed physician. Reimbursement of medical charges for services is limited to those services rendered by a physician licensed to practice medicine in the state in which the charge is incurred.

- Transportation or travel charges, except charges for emergency transportation within the continental United States and Canada for the first trip to and from a hospital by professional ambulance, by regularly scheduled airline, or by air ambulance to and from the nearest hospital qualified to provide special treatment for the illness.

- Any expense that is incurred because of an injury or illness resulting from war or any act of war, whether declared or undeclared.

- Hospitalization, examinations, or medical/surgical treatments and supplies furnished before you or your dependents were covered under this plan, or related to a period of hospital confinement before you were covered under this plan.

- Charges that would not have been incurred if coverage under this plan did not exist, or that you or your covered dependents are not obligated to pay (including expenses which are the responsibility of another coverage).

- Any expense for custodial care, developmental care, or domiciliary care.

- Charges for personal items such as television and telephone rentals while hospitalized.

- Any loss or expense resulting from a covered person's participation in a riot or in the commission of a crime.

Filing Mental Health/Chemical Dependency Claims. CIGNA providers will complete and submit your claims directly to CIGNA so that you do not have to complete any claim forms. You are responsible for paying your share of the cost and CIGNA will pay the rest.

If you use a non-network provider, the provider may require that you pay the full charges and then file a claim for reimbursement with CIGNA. Claim forms for employees who use non-network providers may be obtained from the Benefits Office at 526-2000 or by calling CIGNA at 1-800-455-8187.

Questions regarding your claim may be addressed to CIGNA at 1-800-455-8187 between 8:00 a.m. and 5:00 p.m. (CT), Monday through Friday.

Medical Plan—Administrative Information

Keeping Records. It is necessary to keep separate records of your expenses for each of your dependents and for yourself because the plan operates separately for each covered family member.

Please become familiar with the information needed on the medical claim forms. This will help you keep adequate records so that completing these forms will take less time and effort.

How Your Medical Benefits Are Coordinated. If you or your dependents are entitled to any medical benefits from any other group plan, the ***Benefits by Design*** plan will coordinate benefit payments with payments from the other plans so your **total benefit** from all plans will not be more than 100% of the medically necessary R&C charges (80% or 70% for claims that relate to mental health or chemical dependency care services). This may mean a reduction in benefits under this plan. The company will not coordinate benefits with any individual insurance you purchase on your own.

In a calendar year, this Plan will pay:

- Its regular benefits in full, or
- A reduced amount of benefits. To figure this amount, subtract (B) from (A) below:

  (A) 100% of "Allowable Expenses" incurred by the person for whom claim is made (80% or 70% in the case of mental health or chemical dependency services).

  (B) The benefits payable by the "other group plans". (Some plans may provide benefits in the form of services rather than cash payments. If this is the case, the cash value will be used.)

"Allowable Expenses" means any necessary and reasonable health expense, which is covered under this plan for the person for whom claim is made.

The difference between the cost of a private hospital room and the semiprivate rate is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in this Plan.

Plans that coordinate benefits with the medical plan are:

- Group, blanket, or franchise coverage (except student accident insurance)
- Group prepayment plans, including Health Maintenance Organizations (HMOs)

- Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans

- Any coverage under governmental programs, and coverage required or provided by law, except for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Medicare, or Medicaid

- Other insured or self-insured group coverage.

You must provide information about any additional medical coverage you or your covered dependents have on your claim form. If you do not report other group insurance coverage, claim processing could be delayed.

Which Plan Pays First. To find out whether the regular benefits under this Plan will be reduced, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

- A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

- A plan which covers a person other than as a dependent (for example, as an employee) will be deemed to pay its benefits before a plan which covers the person as a dependent. An exception to this rule is made when the person is also covered by Medicare, and Medicare is both (1) secondary to the plan covering the person as a dependent, and (2) primary to the plan covering the person as other than a dependent. In this situation, the benefits of the plan which covers the person as a dependent will be determined first.

- A plan covering the person as an employee (who is neither laid off nor retired), or as that employee's dependent, pays before a plan covering a person who is laid off or retired (or that employee's dependent). However, if the other plan does not have this rule and the order of benefit payment does not agree between the two plans, this rule does not apply.

- A plan covering the person under a right of continuation pursuant to federal or state law pays after any other plan which covers the person other than such right of continuation. However, if the other plan does not have this rule, and the order of benefit payment does not agree between the two plans, this rule does not apply.

- Except in the case of a dependent child whose parents are divorced or separated, if a child is covered under both parents' plans:

  – The plan of the parent whose birthday falls earlier in a year pays first

  – If both parents have the same birthday, the plan covering the parent longer pays first

- If the other plan does not use the "birthday rule" described above, but instead has a rule based on the gender of the parent, the rules of the other plan will determine the payment order of benefits if different from the order described under this plan.

- In the case of a dependent child whose parents are divorced or separated:
  - If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the "birthday rule" provisions described above will apply.
  - If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
  - If there is not a court decree and two or more plans cover a child, the plan of the parent with custody of the child pays first (if the parent has not remarried).
  - If there is not a court decree and the custodial parent has remarried, that parent's plan will pay benefits first, the stepparent's plan second, and the plan of the parent without custody pays third.

- If none of the above provisions determine the order of benefit payments, the benefits of the plan covering a person longer are determined first, except that
  - The benefits of a plan which covers the person as a laid-off or retired employee, or the dependent of such person, shall be determined after the benefits of any other plan which covers such person as an employee who is not laid-off or retired, or a dependent of such person. If the other plan does not have a provision regarding laid-off or retired employees, this provision will not apply.
  - The benefits of a plan which covers the person under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

Aetna (or CIGNA/Eckerd's as appropriate) has the right to release or obtain any information and make or recover any payment it considers necessary in order to administer this provision.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Third Party Reimbursement. In some cases, this plan may pay expenses for an injury or illness that was caused by another person who could be legally responsible for those expenses. If

that happens, this plan has the right to be repaid or reimbursed from any amounts you may recover from that person or organization.

If you suffer a loss or injury caused by an act or omission of another person, benefits under this plan will be paid only if you (or your legally authorized representative) agree in writing to:

- Reimburse Aetna, up to the full amount of benefits paid under the plan, if damages are collected (subject to applicable law). Damages may be collected by action of law, settlement, or otherwise.

- Provide Aetna with a lien against amounts which may be recovered, equal to the benefits you receive under the plan. This lien may be filed with the third party (from whom damages may be collected), the third party's agent, or a court with jurisdiction over the matter.

The payment and the lien referred to above shall be made or provided to Aetna in its capacity as the provider of administrative services to the plan.

This provision protects the plan's rights to recover any amounts that are paid to you or on your behalf, pending resolution of issues regarding payment liability by the other person and/or his/her agent.

When Your Coverage Ends.

Employee. Your medical coverage will end on the earliest of the following:

- The last day of the month in which your full-time employment ends, except as permitted under COBRA.

- The last day of the month in which you retire, except as permitted under the section titled "Your Benefits at Retirement."

- The last day of the month in which you are no longer eligible.

- The first day of the month in which you no longer make any required contributions for coverage.

- The last day of the period for which your last required payment is made (as in COBRA).

- The day on which the plan ends.

You may continue coverage while you are on unpaid leave of absence (including time off without pay, family medical leave, inactive employee status) only if you continue to pay your monthly cost of coverage during the leave.

Dependents. Medical coverage for your dependent(s) ends on the earliest of the following:

- The day your coverage ends, except as permitted under the section titled "Retirement."
- The last day of the month in which your dependent is no longer eligible for coverage.
- The last day of the month in which the dependent becomes an employee of the company.
- The first day of the month in which you no longer make contributions for dependent coverage.
- The last day of the period for which the last required payment is made by the participant (as in COBRA).
- The day on which the plan ends.

Survivor Medical Benefits. If you die while covered under the medical plan, coverage for your covered dependent(s) will continue until the earliest of the following:

- Three months after the end of the month in which you die.
- The last day of the month in which your dependent(s) is no longer eligible for coverage.
- The last day of the month in which your dependent(s) becomes eligible for Medicare.
- The first day of the month in which your dependent(s) no longer makes contributions for coverage.
- The day on which the plan ends.

Your dependents may be eligible to elect continued coverage under COBRA or to convert their coverage by making appropriate application and paying the cost for the coverage.

Medicare. You will be eligible for coverage under the ***Benefits by Design*** medical plan as long as you remain employed at the INEEL and subject to other eligibility provisions as described previously. If you are still employed full-time at age 65, when your Medicare coverage begins, you may file claims with the ***Benefits by Design*** medical plan as the primary payor and with Medicare as the secondary payor.

The company strongly recommends that you visit your local Social Security Office before you reach age 65 so that all available benefits can be properly explained to you. You may want to apply for Medicare Part B coverage at age 65, even though the BBWI plan is the primary payor.

The company will **not** reimburse Medicare Part B premiums.

More information about Medicare may be obtained by contacting the Social Security Administration.

Your Benefits at Retirement. If you retire *early* (as defined in the INEEL Employee Retirement Plan) and continue to pay the required premiums, you may continue your medical coverage currently in effect until you become eligible for Medicare Part A due to age or disability. (Please note that retirees may continue their coverage either under the provisions of this section, or under COBRA as described in the pages that follow.) You may also cover your dependent(s) who are covered under the plan when you retire until they (1) are no longer eligible for coverage, or (2) become eligible for Medicare Part A due to age or disability, whichever is earlier.

If you elect *normal* retirement, as defined in the INEEL Employee Retirement Plan, you may continue dependent coverage until your dependent is no longer eligible for coverage or becomes eligible for Medicare Part A (due to age or disability), whichever is earlier. Alternatively, your dependents may continue their medical coverage under COBRA as described in the pages that follow.

Subsequent to retirement, retirees may add their eligible dependents who are already covered under the plan (for example, a dependent who is already covered as an active employee). Additionally, retirees may add dependents to their coverage during annual enrollment or if they experience a qualified family status change.

After you retire and become eligible for Medicare Part A, coverage for your eligible dependent(s) will continue if you continue to pay the full "retiree and dependent" premium. Please be aware, however, that coverage for your dependent children will terminate when both you and your spouse are no longer covered.

If you retire and become employed by another company, and if you are covered under that company's group medical plan, that plan will have primary payment responsibility and the ***Benefits by Design*** plan will provide secondary benefits.

The company reserves the right to change the terms and conditions of retiree coverage, and the cost of retiree coverage, at any time.

Conversion Privilege. The plan may allow you and your covered dependents to obtain from Aetna, at your own expense, a personal medical policy without proof of good health upon your ineligibility to be covered by the company group plan. Please note, though, that benefits under your conversion policy will generally not be as extensive as benefits under the ***Benefits by Design*** plan. (See limitations below.)

You will be eligible to take advantage of this provision when your coverage ends (including your continuation rights under COBRA) because (1) your employment terminates due to retirement or otherwise, or (2) you are no longer eligible for medical coverage. Please be aware that if your employment ends due to retirement and you choose to continue retiree medical coverage, you

will not be able to later convert your coverage to a separate policy under this provision. Also, you may not convert if your coverage ends because the group contract for medical coverage is discontinued.

The conversion privilege is also available to your eligible dependents if their coverage terminates (including continuation of coverage under COBRA) because (1) your coverage ends, (2) you die, or (3) they cease to qualify as dependents under the plan.

To be eligible for the conversion privilege, you or your dependent(s) must apply and submit the first premium within 30 days after your coverage ends. Contact your Benefits Office for further information about converting your coverage.

Aetna may decline to issue you and/or your dependents a personal conversion policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy.
- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:
  - Any other hospital or surgical expense insurance policy.
  - Any hospital service or medical expense indemnity corporation subscriber contract.
  - Any other group contract.
  - Any statute, welfare plan or program.

Also, no person will be eligible to convert to an individual policy if:

- He/she has not been covered under the plan for at least three months.
- He/she has used up the $1,000,000 maximum lifetime benefit.
- He/she becomes eligible for other coverage under this plan.

As noted above, coverage under your conversion policy will generally not be as extensive as coverage under the ***Benefits by Design*** plan. For example, the level of coverage may be less and an overall lifetime maximum benefit will apply.

Additionally, the personal policy may contain either or both of:

- A statement that benefits under the personal policy will be cut back by any like benefits payable under this Plan after your coverage ceases.
- A statement that Aetna may ask for data about your coverage under any other plan. This may be asked for on any premium due date of the personal policy. If you do not provide

the requested data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under such other plans.

The personal policy will state that Aetna has the right to refuse renewal under conditions which are specified in the policy.

Extended Benefits-Disability. If you or one of your dependents is totally disabled as a result of a nonoccupational medical condition when your medical coverage under this plan ends for any reason, benefits for that disability only will be continued to the end of the calendar year following the year in which your coverage ends. However, medical coverage will end automatically when the disabled person is eligible for benefits under any other group plan (including Medicare, COBRA, etc.) or is no longer totally disabled.

Continued Coverage (COBRA). If you or your dependent(s) become ineligible for coverage under the ***Benefits by Design*** medical plan, continued coverage as provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA) may be available if you (or your dependents) enroll and pay the applicable costs. Except in cases where coverage is extended due to disability, your cost for this coverage is 102% of the full cost of coverage.

Eligibility for Continued Coverage*.** To be eligible for continued coverage (COBRA), you or your dependent(s) must be covered under the ***Benefits by Design medical plan immediately before you request continued coverage. You may elect to continue the same medical coverage you enjoy as an active employee. (however you will not pay the same contribution that you paid under the Benefits by Design plan.)

You and your covered dependent(s) may continue coverage through COBRA when regular coverage ends due to one of the following events:

- Your full-time employment ends.
- Your employment status changes from regular full-time to temporary or part-time.

Continued coverage is also available to your covered dependents when their regular coverage ends due to one of the following events:

- You die.
- You become divorced or legally separated.
- Your dependent ceases to be eligible for coverage.
- You become eligible for Medicare Part A benefits.

Duration of Continued Coverage. Continued coverage for you and your eligible dependents may extend for up to **18 months** after you end full-time employment or your employment status changes.

Continued coverage for your dependents may extend for up to **36 months** after your death, divorce, legal separation, or eligibility for Medicare Part A. Additionally, your dependents may continue their coverage for 36 months if they become ineligible for coverage.

Coverage may end sooner than the times specified above if one of the following events occurs:

- The cost for a covered individual is not paid within 30 days following the first of the month for which the payment is due. (For example, if the payment for January is not paid by January 31.)

- The covered person becomes eligible, while on COBRA, for Medicare Part A benefits or becomes covered under another group health plan (unless the plan does not cover a pre-existing condition of the covered person).

- The ***Benefits by Design*** plan ends.

If You Are Disabled. Generally, if you or a covered dependent is disabled, the disabled person will be eligible for continued coverage for up to 18 months, whether or not he/she meets the Social Security Administration's definition of "disabled."

Additionally, continued coverage may be extended **after** 18 months if you or your dependent is disabled as defined by Social Security either **on the date** your employment ends (or within 60 days thereafter) or, alternatively, on the effective date of an employment status change that makes you and your dependents eligible for continued coverage.

Under these circumstances, the disabled person will be eligible to continue coverage for up to 11 additional months (up to 29 months **total**). Non-disabled dependents (of the disabled person) who are entitled to COBRA coverage are also eligible for the 11-month extension of coverage. To elect an extension of continued medical coverage for a person who is determined to be disabled under Social Security, you must notify the Plan Administrator by the earlier of (1) 60 days after the person is declared disabled, or (2) the last day of the initial 18-month coverage continuation period. The cost of coverage for the additional 11 months will be 150%, rather than 102%, of the full cost of coverage.

Continued coverage for disability may end sooner than 29 months if you or your dependent is no longer considered disabled by Social Security. Coverage for non-disabled dependents would end if your own coverage were to terminate before the end of the 29-month period.

Election Period/Notification. You have a certain period of time in which to elect continued coverage. If you do not elect continued coverage during this period, or if you give up your right

to continued coverage, your decision is considered final. You will not have another opportunity to elect continued coverage.

The company will notify you, or your dependent(s) if applicable, of the right to continue coverage under COBRA as soon as the company is aware that regular coverage will end because you end active employment, retire, become eligible for Medicare Part A benefits, change your employment status, or die. You or your dependent(s) have 60 days from that notification or the date of the event (whichever is **later**) to elect continued coverage.

You or your covered dependent(s) must notify the Benefits Office within 60 days if eligibility ends due to divorce or your dependent child losing eligibility. The company will then notify you or your dependent(s) of the right to continue coverage. You or your dependents have 60 days from notification by the company to elect continued coverage.

Paying for Continued Coverage. If you or your dependents elect continued coverage, the cost of at least the first month of coverage must be paid within 45 days after you elect continued coverage. You will be charged from the date you become eligible for continued coverage, regardless of when you elected the coverage during the election period. To ensure timely reporting of coverage eligibility and avoid delay in processing your claims, you should remit the contribution amount before the first of the month for which the payment is being made. Your coverage will be terminated without notice if the Benefits Office does not receive your payment within 30 days after the first of the month for which the payment is due.

Payment of Claims. If you or your dependent(s) elect to continue coverage when it is first offered, claims will be payable from the effective date of coverage. However, claims cannot be processed unless you have paid the cost of coverage.

If you or your eligible dependents **do not** elect to continue coverage (COBRA), the ***Benefits by Design*** plan will not pay benefits for expenses you or your dependents have after the date your coverage ends. This applies **even if** the condition being treated began while you or your dependents were covered by the plan. The only exception is if you or your dependent(s) are totally disabled. (See Extended Benefits—Disability).

Definitions

Benefits by Design is a flexible benefit plan offered by the company.

Company means Bechtel BWXT Idaho, LLC.

Custodial care means services and supplies (including board, room, and other institutional care) furnished to a person mainly to help him/her with the activities of daily life, without regard to (1) who prescribes the services, (2) who recommends the services, or (3) who performs the services. The person does not have to be disabled.

Disabled (totally) means you are not able to perform any of the usual and customary duties of any occupation. For dependents, this means your dependent cannot perform any of the usual and customary duties or activities of a person in good health and of the same age.

Durable medical equipment is no more than one item of equipment for the same or similar purpose (such as a hospital bed, wheelchair, etc.) and the accessories needed to operate it. Durable medical equipment is:

- Made to withstand prolonged or repeated use.
- Made for and primarily/customarily used to treat a disease or injury.
- Not generally useful to the person in the absence of an illness or injury.
- Appropriate for use in the home.
- Not for use in altering air quality or temperature.
- Not for exercise or training.

Durable medical equipment does not include nonmedical equipment, such as sun or heat lamps, heating pads, whirlpool baths or spas, portable whirlpool pumps, sauna baths, massage devices, overbed tables, exercise devices, ramps, handrails, elevators, communication aids, vision aids, telephone alert systems, air conditioners, air purifiers and humidifiers.

Emergency admission means an admission in which a physician admits the person to a hospital or treatment facility immediately following the sudden and (at that time) unexpected onset of a change in a person's physical or mental condition which:

- Necessitates immediate confinement as a full-time inpatient, and
- Can be reasonably expected (as determined by Aetna) to result in loss of limb/life, significant impairment of bodily function, or permanent dysfunction of a body part if immediate inpatient care is not given.

Employee means a regular full-time employee of the company.

Extended care facility (skilled nursing care facility) is an institution (or distinct part of an institution) that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury.
  - Professional nursing care by a R.N., or by a L.P.N. directed by a full-time R.N., and

– Physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges a fee for services rendered.

The plan will pay extended care facility benefits only if:

- The confinement is under the supervision of a physician, and
- Hospital confinement would be necessary in the absence of extended care facility confinement.

Home health agency is a public agency or private organization, licensed and operated in accordance with state law, that:

- Primarily provides skilled nursing services and other therapeutic services.
- Has policies developed with the advice of a group of professionals, including at least one physician and at least one registered professional nurse (R.N.), to govern the services provided, and has a physician or registered professional nurse supervise health care services.
- Maintains clinical records on all patients.
- Is licensed under state or local laws, or meets the licensing standards of the state or local area.
- Meets other conditions established under Medicare to protect the health and safety of individuals who receive home health care services.

Home health care plan means a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- Prescribed in writing by the attending physician; and

- An alternative to confinement in a hospital or convalescent facility.

Hospice care is care given to a terminally ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice care agency is a public agency or private organization that provides care and services for terminally ill persons and their families. The hospice must meet Medicare requirements, or meet all of the following requirements:

- Provide Hospice Care services 24-hours-per-day.
- Provide skilled nursing services, medical social services, and psychological/dietary counseling.
- Provide or arrange for other services including services of a physician, physical/occupational therapy, part-time home health services which consist mainly of caring for terminally ill persons, and inpatient care in a facility when needed for pain control and acute/chronic symptom management.
- Have a staff of employees that includes at least one physician, one registered professional nurse (R.N.), and one social worker to coordinate the care and services provided.
- Establish policies governing the provision of Hospice Care.
- Assess the patient's medical and social needs and develop a Hospice Care Program to meet those needs.
- Provide an ongoing quality assurance program. This includes reviews by physicians, other than those who own or direct the Agency.
- Permit all area medical personnel to utilize its services for their patients.
- Keep a medical record on each patient.
- Utilize volunteers trained in providing services for non-medical needs.
- Have a full-time administrator.
- Be licensed, certified, or accredited as a hospice, if required by local laws.

Hospice care program is a written plan of hospice care which:

- Is established by, and reviewed from time to time by, (1) a physician, and (2) appropriate personnel of the Hospice Care Agency.

- Is designed to provide palliative and supportive care to terminally ill persons and supportive care to their families.

- Includes an assessment of the person's medical and social needs, and a description of the care to be given to meet those needs.

Hospital is an institution licensed by the state as a hospital, approved as a general hospital by the Joint Commission on the Accreditation of Hospitals (JCAH), and operated in accordance with the laws for care and treatment of sick and injured persons. The hospital must (1) be supervised by a staff of physicians, (2) provide 24-hour nursing care and (3) have facilities for medical diagnosis, surgery (unless the hospital primarily treats chronic illnesses), treatment, and care of injured and sick persons. For the purpose of this definition the Idaho Falls Recovery Center, licensed by the State of Idaho, will be considered a hospital.

A fully state-licensed treatment facility approved under the ***Benefits by Design*** plan that primarily treats alcohol or chemical dependency will also be considered a hospital for benefit purposes when you or your dependent is confined under an active treatment program (up to 30 days continuous confinement or as otherwise approved by the plan administrator).

"Hospital" does **not** include hotels, rest homes, convalescent homes, places for custodial care, nursing homes, or homes for the aged.

Hospital confinement means a medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board and regardless of how the hospital classifies the stay. Any hospital confinement satisfying this definition will be subject to all policy provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements.

Injury is a bodily injury sustained accidentally by external means.

Medical emergency is a severe condition that, in the opinion of Aetna's medical staff and/or an independent medical review (or CIGNA for mental health and chemical dependency situations):

- Results in symptoms that occur suddenly and unexpectedly, and

- Requires immediate care by a physician to prevent death or serious impairment of the covered person's health.

Medically necessary. Services or supplies are those furnished by a particular covered provider which Aetna (CIGNA for mental health and chemical dependency services or Eckerd's for prescription drugs) determines are appropriate for the diagnosis, care or treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply both as to the disease or injury involved and the person's overall health condition.

- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition.

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances. Aetna (or CIGNA/Eckerd's as appropriate) will take into consideration all of the following:

- Information provided on the affected person's health status.

- Reports in peer reviewed medical literature.

- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data.

- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment.

- The opinion of health professionals in the generally recognized health specialty involved in such opinion.

- Any other relevant information brought to the attention of Aetna (or CIGNA/Eckerd's as appropriate).

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, a mental health or a dental professional.

- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility.

- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined in a hospital.

- Those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Morbid obesity is a condition as determined in accordance with Aetna's underwriting standards.

Network provider means:

- A hospital, physician or other provider of health care services/products recognized by the plan that has entered into a written agreement with CIGNA, Eckerd's or CCN-Premier (on behalf of the Southeast Idaho Employers Coalition) to provide health care services to covered persons under the plan at pre-negotiated rates.

- Radiologists, anesthesiologist, pathologist, emergency room, and other physicians who are network hospital-based will be considered Network Providers if a covered person utilizes a network hospital for services related to a hospital confinement or a surgical procedure. Additionally, charges by out-of-network laboratories, radiologists, anesthesiologists, and pathologists will be reimbursed at the in-network schedule of benefits if the services obtained are the result of referral by a network provider. Allowable expenses for services and supplies furnished by such providers shall be based on reasonable and customary charges.

- A provider may be named by the company as an exclusive provider. Allowable expenses for services and supplies furnished by such providers shall be based on reasonable and customary charges.

Non-network provider means a hospital, physician or other health care provider that has not entered into a written agreement with CIGNA, Eckerd's or CCN-Premier (on behalf of the Southeast Idaho Employers Coalition) to provide health care service products to Covered Persons under the plan at pre-negotiated rates.

Nonoccupational injury or illness is an accidental bodily injury or illness that does not (1) arise out of, or in the course of, any work for pay or profit, or (2) result in any way from an injury which does. An injury or illness will be deemed to be nonoccupational (regardless of cause) if proof is furnished that the person is covered by Worker's Compensation, but is not covered for that injury or illness.

Physician is a person legally licensed to practice medicine and perform surgical procedures, or any other licensed health care practitioner that state law requires to be recognized as a physician for purposes of group insurance coverage.

Reasonable and customary charge for a service or supply is the lowest of the following amounts:

- The provider's usual charge.

- The charge Aetna (or CIGNA as appropriate) determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made.

- The charge Aetna (or CIGNA as appropriate) determines to be the 90th percentile of prevailing charges for that service or supply.

In determining reasonable and customary charges for services/supplies that are unusual, infrequently provided, or provided by only a small number of area providers, Aetna (or CIGNA as appropriate) may take into account factors such as:

- The complexity of the services.

- The degree of skill needed.

- The type of specialty of the provider.

- The range of services or supplies provided by a facility.

- The recognized charge in other areas.